tive mortality, 0 per cent.; subsequent death, four (57 per cent.); cured, 4.5 per cent.; improved, 13.6 per cent. Eleven times primary nephrectomy was performed, secondary nephrectomy sixteen times.

Most of the times the capsule was left behind. For the pedicle the rubber ligature was abandoned and replaced by silk. Where possible, the ureter was resected for a short distance. Out of twenty operated cases, results, 59.2 per cent., sixteen patients were cured and seven improved. The operative mortality of primary nephrectomy is 18.1 per cent.; that of secondary nephrectomy, 6.02 per cent. Comparing 59 per cent. cures of nephrectomy with 4.5 per cent. cures in nephrostomy, it is self-evident that the former is preferable; but the latter is indicated when the kidney is converted into a pus sac, and if the kidney be secured by adhesions; if the opposite kidney be diseased or absent and when cachexia is marked and the diagnosis uncertain. A primary nephrectomy is the ideal procedure if the disease be early recognized. It implies one operation, one narcosis. The total result of thirty-five cases is, seventeen (48.5 per cent.) are living, thirteen (37 per cent.) cured. This latter figure could be raised to 68 per cent. if the cases that lived but three years were included, as well as those dead from associated tuberculosis elsewhere.—*Beiträge zur klinischen Chirurgie,* Band xxx, Heft 1.

MARTIN W. WARE (New York).

RECTUM AND ANUS.

I. Retrograde Dilatation of Inflammatory Rectal Strictures. By DR. VICTOR LIEBLEIN (Prag). **II. Exclusion in the Treatment of Rectal Strictures.** By DR. HERMANN SCHLOFFER (Prag). The former procedure is applicable to such rectal stenoses non-malignant in character which are impervious to bougies introduced from the anus. Before any extensive resection for impervious stricture is undertaken an artificial anus is made. The bougie is guided into the stricture by placing

into the descending loop a fillet of silk with a shot attached to one end, the free end being held out on the abdomen. The peristalsis of the bowel expels the shot with silk attached to it. To the free end of the silk fillet larger and larger bougies are successively attached and guided into the stricture by traction on the thread at the anus. When dilatation of the stricture has proceeded so far that passing of bougies from the anus is feasible, attempts at retrograde dilatation are no longer persisted in.

The advantages of this procedure are the avoidance of false passages, the practicability of leaving the bougie longer in the grasp of the stenosis, thereby hastening dilatation.

In one of the instances where the above procedure failed to effect a permanent cure, the method of intestinal exclusion was resorted to. The sigmoid flexure was made to anastomose with the rectum below the level of the stenosis. The anastomosis was done with the Murphy button, but the orifice between the rectum and sigmoid subsequently contracted, but was much easier of dilatation by the introduction of the finger from the anus.—*Beiträge zur klinischen Chirurgie,* Band xxxi, Heft 3.

MARTIN W. WARE (New York).

EXTREMITIES.

I. A New Method of Reducing Dislocations of the Shoulder. By DR. F. HOFMEISTER (Tübingen). The principle of this method consists in the application of a systematic permanent extension of the upper extremity by weights. The incentive to this procedure emanated from Stimson's plan to place the patient in a hammock and allow the arm to pass through a hole in the hammock, and by attaching weights, eight to twelve pounds, to the dependent arm, a reduction is accomplished within four to six minutes. The author finds this method efficient, yet enumerates as drawbacks the great pressure exerted on the axilla by the hole in the hammock, which tends to increase the venous stasis favored so strongly by the dependent position of the arm. Both